

FILED VS MAR 7 1960

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

-60-005714  
 STATE FILE NUMBER

Registration District No. 109 Primary Registration District No. 4180 Registrar's No. 6

V. S. 300  
 Rev. 1-57  
 3, 50

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only): OR TOWN <b>Campbell</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Campbell 03500</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home 90</b>		Length of stay in lb <b>3 weeks</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>F.</b> Last <b>Keith</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1960</b>		
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/14/1882</b>		9. AGE (In years last birthday) <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Washington, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>George Keith</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Banta</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Lillie Keith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Lillie Keith, Campbell, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b>					<b>2 years</b>
DUE TO (c) <b>4200</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Jan. 1958</b> to <b>Oct. 1958</b> and last saw her alive on <b>Oct. 3, 1958</b> Death occurred at <b>8 P. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Robert C. Engelhardt</i>			22b. ADDRESS <b>Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>2-3-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>Removal &amp; Burial</b>		<b>1/29/1960</b>	<b>Plainville,</b>		<b>Plainville, Indiana</b>
24. FUNERAL DIRECTOR ADDRESS <b>Frank-Cotrell Chapel, Poplar Bluff Mo.</b>		25. DATE REC. BY LOCAL REG. <b>2-5-60</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Bertha Sampson</i>		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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MS MAR 7 - 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Charles E. Mungel*

Licensed Embalmer No. 4877

P. O. Address Poplar Bluff

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.